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Parental perceptions of children clinically diagnosed as Affective Disorder, Attention Deficit Hyperactivity Disorder, or Conduct Disorder: The implications for family therapy

Pamela McComas Vaught
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Vaught, Pamela McComas, Ed.D.

The College of William and Mary, 1990

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PARENTAL PERCEPTIONS OF CHILDREN
CLINICALLY DIAGNOSED AS AFFECTIVE DISORDER,
ATTENTION DEFICIT HYPERACTIVITY DISORDER, OR
CONDUCT DISORDER: THE IMPLICATIONS FOR
FAMILY THERAPY

A Dissertation
Presented To
The Faculty of the School of Education
The College of William and Mary In Virginia

In Partial Fulfillment
Of The Requirements For The Degree
Doctor of Education

by
Pamela McComas Vaught
May 1990

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Dedication

To my parents who have always encouraged and supported
as well as scarified for my educational endeavors.

TABLE OF CONTENTS

	Page
DEDICATION	iii
ACKNOWLEDGEMENTS	vii
LIST OF TABLES	viii
ABSTRACT	ix
 CHAPTER	
1. INTRODUCTION	2
Justification	2
Statement of the Problem	6
2. REVIEW OF THE LITERATURE.	9
Theoretical Rationale: A Review of	
Interactional Theory.	9
Summary of Parent-Child Interaction and	
Specific Diagnoses	17
Summary of Research on Diagnosing Children	23
3. METHODOLOGY	27
Specific Null Hypotheses	27
Definition of Terms	28
Instrumentation.	29
Population and sample	33
Data Collection	34
Data Analysis	36
Ethical Considerations	37
Limitations of the Study	37

Summary	39
4. RESULTS	40
Total Sample Demographics	40
Demographic Results by	
Diagnostic Group	43
Evaluation of the Null Hypotheses	48
Null Hypothesis I	48
Null Hypothesis II	50
Null Hypothesis III	51
Null Hypothesis IV	52
Null Hypothesis V	56
Summary	59
5. SUMMARY, CONCLUSIONS, DISCUSSION AND	
RECOMMENDATIONS	62
Summary	62
Conclusions	65
Discussion	70
Recommendations for Future Research	77

APPENDICES

A. Parental Participation Consent Form	80
B. Demographic Information	82
C. Revised Behavior Problem Checklist	85
D. Diagnostic Criteria for Attention	

Deficit Hyperactivity Disorder89
E. Diagnostic Criteria for	
Conduct Disorder92
F. Diagnostic Criteria for	
Affective Disorder95
BIBLIOGRAPHY102
VITA110

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Finally, my deepest thanks to my husband, Kevin, who was always there with his support just when I needed it most.

LIST OF TABLES

Table	Page
1. Means of Parents combined scores on the RBPC scales	54
2. Means of mothers and fathers scores on the RBPC scales	57

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Abstract

The purpose of this study was to investigate parental perceptions of children clinically diagnosed as Affective Disorder, Attention Deficit Hyperactivity Disorder, or Conduct Disorder. The results were assessed in reference to their implications for family therapy.

The sample utilized in this study was 97 sets of mother-father dyads who sought psychiatric intervention for their child at local mental health clinics. The mother-father pairs in these intact families completed a demographic questionnaire and the Peterson-Quay Revised Behavior Checklist. The data were analyzed using frequency analysis, t-tests, and multiple regression analysis.

This research indicates that there are significant differences between parents' perceptions of their child across three diagnostic categories and between mothers and fathers.

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CHAPTER I

INTRODUCTION

JUSTIFICATION:

"What is meant by a family? . . . the very omnipresence of the family renders it almost invisible. Because we are truly immersed in the family we rarely have to define it or describe it to one another" (Degler, 1980, p. 3).

The family system is not just another system. It is unique and powerful. Its effects are rooted in blood ties and emotional bonds of love and hate which shape the individual being in a way no other social system can begin to equate. Due to its long collective history, relationships within the family are more intense than in any other group (Framo, 1972). Its members unconsciously act out predetermined roles. The myths and secrets in a family and the shared unconscious ideas and perceptions of the family group act directly on its sons and daughters from generation to generation.

As family systems theory has evolved, the interaction between various family members has been explored. With the readvent of the focus on families and their importance in the American society, the impact on

family member interaction, specifically parent-child interaction, has drawn significant interest and attention by family researchers. "It is clear that man as a system is ecologically situated in many systems, the most important is the family" (Framo, 1972, p.26). Parsons and Bales (1955) indicated that "By virtue of being a small group the nuclear family is relatively a very simple social system, and we believe this fact to be of the greatest importance for its functioning as the agency of socialization and as personality stabilization. . . ." (p. viii).

Warner (1981) stated that part of a system influences other parts. The postulation that a family unit could be classified as a system began shortly after general systems theory built a foundation. Members of a family interact with and influence one another much as individuals within a system interact with and influence one another. The entire family unit participates in family development. Family therapy's roots may not have been recognized until later decades; however, a very early ancestor of psychotherapy referred to families: "It follows from the nature of the facts which form the material of psychoanalysis that we are obliged to pay as much attention in our case history to the purely human

and social circumstance of our patients as to the somatic data and the symptoms of the disorder. Above all our interest will be directed to their family circumstance and not only as will be seen later, for the purpose of inquiring into their heredity" (Freud, 1905, p. 18).

Much research has been conducted on family systems. Noticeably lacking, however, has been even descriptive data on parents' perceptions of their children and the impact those perceptions may have on the family. Most research addressing parents and their children addressed parent-child interaction contingent on individual personality characteristics of the parents (Beardslee, Bemporad, Keller, & Klerman, 1983; Cantwell, 1972; Stewart, DeBlois, & Cummings, 1980). These studies also utilized normal controls and no comparison was made between varying psychiatric diagnoses. Mash and Johnston (1983) researched parental perceptions of children in a specific diagnostic category and suggested that similar investigations with parents of children with other diagnoses may help to clarify many remaining questions regarding parental perceptions.

" Only the family, society's smallest unit, can change and yet maintain enough continuity to rear children who will not be 'strangers in a strange land',

who will be rooted firmly enough to grow and to adapt" (Minuchin, 1974, p. 47). It followed then that the most obvious choice of intervention with children in need of psychiatric services would be that of family therapy. ". . . in consideration of therapeutic work with children and parents, the family therapy approach warrants careful consideration as a potentially useful intervention and, dependent upon assessment and evaluation, in some cases proves to be the treatment of choice" (Mishne, 1983, p. 198). In the family system children often bear the burden of their parents; parents frequently turn to children who develop symptoms that express their parents' conflict as well as their own.

Chethik (1976) notes that there is a deficit in the literature on work with parents. Family therapy advocates the inclusion of the parents in the therapeutic setting and often embarks on parent-therapist alliance to address issues of resistance. Often parents relive their relationships with their family of origin through their children and it is not until they are confronted in the therapeutic setting that they become aware of this reality. When working with children, Sours (1978) believes that parents should be seen regularly in order to increase their understanding of the child's behavior

and pathology; thus producing change in their attitudes and interactions with the child.

This study investigated the perceptions parents have of their children who have varying psychiatric diagnoses and the implications those perceptions have for family therapy.

Statement of the Problem

Researchers in the field of child psychology (Barkley, 1984; Patterson, 1980; Weissman, John, Merikangas, Prusoff, Wickramaratne, Gammon, Angold, & Warner, 1986) have investigated conduct disorder, attention deficit hyperactivity disorder, and affective disorder quite extensively. All studies cite either the significance of the parental interaction or the assessment of parental psychiatric disposition in providing productive interventions for these children and their families.

In today's society, a child with a psychiatric diagnosis is a complex phenomenon. This child needs the support and guidance of a strong parental hand. Parents understanding their perceptions of their child's psychiatric difficulty may be the key to coping with and enhancing a child's life.

The purpose of this study was to investigate parental perceptions of children who were clinically diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD), an Affective Disorder (AD), or a Conduct Disorder (CD). Differences in parents' perceptions were assessed in reference to their implications for family therapy. More specifically, this study sought to determine the answers to the following research questions:

1. Will mothers and fathers with a conduct disorder child score significantly higher on the Conduct Disorder (CD) scale and Socialized Aggression (SA) scale of the Peterson Quay Revised Behavior Checklist (RBPC) than parents of an attention deficit hyperactivity disorder child or an affective disorder child?
2. Will mothers and fathers with an attention deficit hyperactivity disorder child score significantly higher on the Attention Problems-Immaturity (AP) scale of the RBPC than those parents with a conduct disorder child or an affective disorder child?
3. Will mothers and fathers with an an affective disorder child score significantly higher on the Anxiety-Withdrawal (AW) scale of the RBPC than parents with a conduct disorder or attention deficit hyperactivity

disorder child?

4. Will mothers and fathers perceptions of their child differ?

5. Will there be a correlation between parents' perceptions and several demographic factors including child's diagnosis, parent's education, socioeconomic status, child's age, child's sex, child's grade, number of children in the family, parents relationship to the child, length of parents marriage, parent's rating of their marriage, parent's employment status, parent's age at which they had this child, parent's ratings of how their child was as an infant, level of stress parents experienced during child's first three years, time the parent spends with the child, age at which parents recognized the problem, referral source, who drives child to therapy, and the parents willingness to participate in treatment.

Ascertaining parental perceptions will aid in educating parents regarding their interactions with their children based on those perceptions. This study will also assess parental perceptions correlated with the severity of the psychiatric diagnosis of the child.

CHAPTER II

REVIEW OF THE LITERATURE

Chapter II surveys major literature which relates to the topic under investigation. This chapter is organized into three categories:

1. Theoretical Rationale: A Review of Interactional Theory through a review of the history of parent-child research.

2. Summary of the relevant research of parent-child interactions and their relationship to the research problem, and

3. Summary of research on diagnosing children as Attention Deficit Hyperactivity , Affective, and Conduct Disorder.

THEORETICAL RATIONALE: A REVIEW OF INTERACTIONAL THEORY

The involvement of psychology and psychiatry in the study of family behavior has occurred only within the last few decades, notwithstanding the contributions of major personality theorists such as Freud, Lewin, and Erikson (Handel, 1965). Due in part to the late emergence of family therapy on the psychiatric scene,

other disciplines have contributed to the model of family interaction which seems to have gained acceptance by the theorists and practitioners of today. ". . . contributions from family sociology, systems and communications theory, child and developmental psychology, and social learning theory evolved nearly 15 years ago. . ." (Jacob, 1987, p.5). The theoretical perspective referred to as interactional theory embodies two major components: 1) identification of family patterns and processes which are precursors, concomitants, and consequences of disordered behavior, and 2) integration of this knowledge into the broader family studies literature (Jacob, 1987).

Many of the popular family therapy approaches make liberal references to systems theory in their roots. Strategic family therapy (Haley, 1976; Madanes, 1981; Selvini-Palazolli, Cecchin, Prata, & Boscolo, 1978), structural family therapy (Minuchin, 1974), and the Bowen model (1976) have all advertised systems theory as a basis for their beginnings. Much like other family therapy models, interactional theory attributes some of its heritage to systems theory. One clearly sees that interactional theory addresses involvement with others and the impact that involvement may have on an

individuals' mental health.

The systems view of family interaction is a set of theoretical postulates which have generated a number of systems models of families. All of the models of family therapy including interactional theory share one common thread; the conceptualization of the family as an operational system. Systems thinking has been referred to as "scientific paradigm" (Gray, Duhl, & Rizzo, 1969), a new "world view" (Ritterman, 1977), and a new "epistemology" (Dell, 1982). ". . . the model that has had perhaps the greatest impact on thinking and practice in the family field: family systems theory" (Jacob, 1987, p. 26).

Identifying interactional theory as an outgrowth of systems theory provides a different approach to causality in that pathology may be defined in terms of "malfunctional interactions between factors or components within a system" (Steinglass, 1987, p. 28). Hence, the important question is identifying factors in the psychiatric population which contribute to the pathology or breakdown of systemic processes.

In attempts to unravel the mystery of relationships among family members and dysfunctional behavior various theoretical perspectives have been exploited. Often

researchers have emphasized the individual family member as the key to the dysfunction. Some researchers identify the family group as the impetus of the dysfunction. "Although interest in relational parameters has been strongly implied throughout much of this literature, programmatic studies of interaction per se have been undertaken only since the mid 1950's" (Jacob, 1987, p.3). Even the earliest clinical studies alluded to the family's role in dysfunctional behavior (Fromm-Reichman, 1948; Lewis, 1937). A number of subsequent studies detailed the personality characteristics of individual family members (e.g., Jacob, Favorini, Meisel, & Anderson, 1978).

The advent of interactional theory as a means of conceptualizing human interaction can best be illustrated by examining the history of parent-child interactions. A discussion of the history of parent/child interaction can be divided into two sections: the effect adults have on children and the effect children have on adults. It must be noted that much of the literature addressing psychiatric problems in children does not focus on the family interactional component as a critical component to the child's dysfunction; individual child and individual parent personality characteristics are often delineated

throughout the research (Cameron, 1978; Cantwell, 1972; Weissman, et.al, 1986).

Investigations of parental psychopathology and the impact it exerts on children during early childhood and adolescence have been conducted toward identifying high risk family members (Garmezy, 1974). However, literature on interaction states, "In essence, dyadic interchanges between the target child and other family members would be considered the units of immediate diagnostic interest" (Wahler & Dumas, 1987, p.585). Further, Wahler and Dumas (1987) speculated that not only does the family have a direct impact on a child's psychopathology through parental approval or disapproval, but the family also indirectly impacts on the child through aspects such as social isolation and marital conflict.

Becker, Peterson, Hellmer, Shoemaker, Luria, and Quay (1959; 1962) indicated that a cold, rejecting father may contribute more to a child's dysfunction than a cold, rejecting mother. Martin and Hetherington (1975) conducted research on the difference in mother's and father's interactional behaviors with their children and suggested that a lack of acceptance by the same sex parent but average acceptance by the opposite sex parent may be related to child withdrawal and dependency.

However, they conclude their results by stating that no definitive patterns have been established and that further research is needed to clarify the father-child relationship.

Studies by several reserachers (Belle, 1982; Bond & McMahon, 1984; Conger, 1984) all utilize maternal reports as an index of family stress stating that the level of stress experienced by the major caretaker has been shown to be an important predictor of chidrens behavior problems. The adult's effect on a child may be no more clearly seen than through a 1980 study by Kokes, Harder, Fisher, and Strauss which showed that child incompetence in a school-age sample was related to the affective relationship between the mother and child.

Wallerstein (1987), in her research on children of divorced families, found that father's psychological relationship with the child was highly correlated to the childs level of adjustment. The more distressed responses to the divorce occurred among the boys whose attachment to the father remained intense. Wallerstein also found that the father-child relationship, although poor, gained greater psychological significance during adolescent years, particularly for boys. Although she concluded that the child of divorced parents generally

turns to the appropriate parent at various developmental levels, failure of that parent to respond appropriately can result in bitter, tragic disappointment. Mishne (1983) indicates that involvement of the father in therapy often means the difference between failure and success in parent contacts and ultimately therapeutic intervention. Research assessing parent-child interactions and academic performance in adolescents indicated that " . . . interactions with fathers, who have typically been ignored in the psychological literature, were significantly related to school behavior and academic performance" (Forehand, Long, Brody, & Fauber, 1986, p. 1532).

The interest in the dyad of child-parent and the child's effect on the parent has been described in an early attachment study conducted by Ainsworth and Bell (1974). This study indicated that maternal responsiveness was associated with the development of other aspects of social competence in children. Studies of temperamental differences in children associate difficult temperaments with less positive interactions within the parent-child dyad (Thomas, Chess, & Birch, 1970). Further studies indicate an association between temperamental characteristics and behavioral symptoms

(Wertlieb, Weigel, Springer, & Feldstein, 1987).

Parenting a difficult child may adversely effect the manner in which mothers perceive their child, their role as a parent, and themselves (Mash & Johnston, 1983).

The majority of research conducted on parent-child dyads are specific to the mother-child dyad. Perhaps studies of the father-child relationship have been limited because the research which does exist indicates that fathers generally view their child's dysfunction as less severe (Firestone & Witt, 1981). The father-child relationship has only recently begun to be studied to any extent. Fathers of withdrawn boys were found to be less accepting than fathers of normal or aggressive boys (Martin & Hetherington, 1975).

Bugental, Love, and Kaswan (1972), in a study of family interaction, found that fathers of "normal" versus "disturbed" children, not mothers, showed significant differences. Fathers of normal children were found to be generally neutral, nondirective, and untalkative. Fathers of disturbed children were found to be controlling and/or dependent, talkative, neutral, nondirecting, or negatively extreme, dependent on the child's type of disturbance.

Clearly, a review of interactional theory can most

efficiently be conducted by identifying studies which delineate the interaction between adult-child and child-adult. The previously cited studies indicate that both the child and the adult effect one another in a manner which makes the studying of family interaction critical to any research with children and their families. In fact, Ricks (1985) reported a study which shows intergenerational transmission regarding the security of parent-child relationships; the quality of the relationship between a parent-child relates to the quality of the parents childhood relations with their parents.

Summary of Parent/Child Interaction and Specific Diagnoses

The majority of the research conducted on parent-child dyads and interactions has utilized normal probands. A child with a psychiatric diagnosis in today's society is a complex phenomenon. Researchers in the field of child psychology have investigated conduct disorder, attention deficit hyperactivity disorder, and affective disorder quite extensively. These studies cite either the significance of the parental interaction or the assessment of parental psychiatric disposition in

providing productive interventions for these children and their families.

Attention deficit hyperactivity disorder (ADHD), in most literature synonymous with hyperactivity, is perhaps the most common presenting problem in child psychiatric clinics. It is also a disorder that has changed, to some extent, as various versions of the DSM have been produced. Consequently, a review of the research prior to the advent of the DSM-III-R (1987) requires some caution given variations in diagnostic criteria over time.

As with affective disorder children, ADHD children have been studied extensively throughout the literature. Primarily, the research has addressed the characteristics of the ADHD child. However, in terms of mother-child interactions, Cunningham and Barkely (1979) found that mothers of normal children initiated significantly more social interactions than those of ADHD children; mothers of normal children encouraged their child's play by interacting positively, praising, or questioning the child significantly more than mothers of ADHD children; mothers of normal children gave half of the commands that mothers of ADHD children gave; and mothers of normal children rewarded off task responses less frequently than

mothers of ADHD children. In 1985 Traver-Behring, Barkely, and Karlsson explored the mother-child interactions of ADHD boys and their normal siblings. The results showed that mothers reacted less positively to the compliance of the ADHD boys compared to their normal siblings. Several researchers (Barkely, 1984; DeHaas, 1986) have suggested the need for further research in the area of families with ADHD children. Parent's perceptions of ADHD children have only minimally arisen in the literature and ADHD children and their fathers' interactions have been only briefly addressed (Mash & Johnston, 1983).

The DSM III-R diagnosis of Affective disorder encompasses a continuum from severe depression to dysthymia (mild depression). The research abounds with articles pertaining to the enigma of childhood depression. Most articles (Achenbach, 1966; Kerr, Hoier, & Versi, 1987; McGee & Williams, 1988; Schulterbrandt & Raskin, 1977) indicate that depression in children remains uncertain. Still, as with conduct disorder children, the research is limited to data regarding individual personality characteristics of either parent or child. Weissman, Paykel, and Klerman (1972) examined the family life cycle of depressed women and found that

they were significantly more impaired mothers. Their impairments with their children included diminished emotional involvement, disaffection, impaired communication, increased hostility, and resentment. Mothers of school-age children who were depressed were often irritable, uninvolved, and intolerant of the children's noise and activity (Weissman, Paykel, & Klerman, 1972). The concern about parents with affective disorders is presented widely throughout the literature. Beardslee et al (1983) published a comprehensive review of the literature pertaining to parents with affective disorders and their children. They ascertained that "... offspring of parents with affective disorders have higher rates of psychological difficulties and, in particular, higher rates of affective disorder than offspring of parents without such illness" (Beardslee et al, 1983, p.825). "The children of ill parents were less creative, showed less initiative, and less need for closeness with teachers. . . ." (Beardslee et al, 1983, p. 828). These studies have several limitations including inconsistent definitions of diagnoses; small sample numbers; and limited assessment of fathers depressive characteristics.

Of particular interest is the idea that research in

childhood depression appears predicated on the assumption that child and adult forms are identical (Werry, 1987). McGee and Williams' (1988) research adds to the growing literature which supports the idea that child and adult forms of depression are indeed somewhat different.

The research of James Coyne (1976) most closely addresses the depressed person in terms of interaction with others. Coyne postulates that depression is at least in part a characteristic of a persons interaction with the environment. This development has specific implications for a study of interactions between depressed children and their families. Coyne (1985) further describes the interactional model of depression in reference to marital interactions stating that depressed persons often have tense and negative marital interactions. Utilizing an interactional theory and noting previously cited research on parent-child interactions, one can then surmise that if marital problems exist the child will be effected by them. Treatment of the parents' depression may have an impact on the health of the child (Weissman, Gammon, John, Merikangas, Warner, Prusoff, & Scholonskas, 1987).

Mental health practitioners state that conduct disorder children represent the largest percentage of

adolescent clients in their centers (Wells & Forehand, 1981). Yet, much of the research on parents and their children who have been clinically diagnosed as having a conduct disorder is limited to descriptive information regarding the individual personality characteristics of either the child or the parent. Stewart, DeBlois, and Cummings (1980) examined parents of conduct disorder children via a structured interview. Generally, the results indicated that antisocial personality and alcoholism were common in natural fathers. Spouse abuse was common among the parents of these children. The conduct disorder children tended to come from large families who had lower SES than most families. ". . . antisocial personality in fathers is associated with aggressive behavior in boys" (Stewart, DeBlois, & Cummings, 1980, p. 289). As with most studies pertaining to children with DSM III or DSM-III-R diagnoses, these studies have very small samples. No mention is made of parents perceptions of their children, simply their personality characteristics are delineated.

No studies which address the interactional patterns between conduct disorder children and their parents were found by this author. The difficulty in studying interactional patterns may contribute to the lack of

research available.

Summary of Research on Diagnosing Children

Although adult disorders received considerable study during the nineteenth century, childhood disorders did not begin to attract attention until the turn of the twentieth century (Achenbach, 1980). Lightner Witmer, who began the first American psychological clinic in 1896, is given credit for originating the assessment of childhood disorders in this country. Still, these assessments remained limited and it was not until 1915 when surveys by the National Committee for Mental Hygiene revealed widespread emotional problems among school-age children that the mental health needs of children received much attention (Achenbach, 1980). In 1922, child guidance clinics became the primary vehicle for mental health services to children and, in 1924, the American Orthopsychiatry Association was founded to work primarily with troubled children.

Even though progress has been made in the diagnostic assessment of children, there remains a hiatus between the progress adult diagnostic assessments have made and that of children. Generally, the assessment of children has been excluded from studies with a psychiatric

emphasis. This is due in part to the lack of systematic diagnostic techniques for the assessment of children comparable to those used with adults (Weissman, et al., 1985). There also remains uncertainty about the applicability of adult diagnostic criteria to children. Traditionally, child psychiatric assessment has not focused on symptoms but rather on information provided by the parent and an interview with the child.

The appearance of the Diagnostic and Statistical Manual for Mental Disorders (DSM-III) was ". . . a watershed in the nosology and classification of childhood psychopathological disorders in that it standardized the definition of, and the diagnostic criteria for, such disorders" (Werry, Reeves, & Elkind, 1987). The DSM-III appeared in 1974 and due to its international popularity and standardized definitions, it for the first time offered the possibility of a testable and universal diagnostic system for children as well as adults. Quay (1986) conducted numerous studies on the reliability and validity of the DSM-III as a psychiatric classification system for children. The results of his findings indicate two major criticisms: the inappropriateness of the medical, disease, or categorical model, and the overdefined, untested, and excessive number of categories

and subcategories. Although Quay (1986) cites these criticisms, he does state that most of the major categories are reliable.

The publication of the DSM-III gave child psychiatry the first detailed diagnostic definition of attention deficit hyperactivity disorder (Lahey, Pelham, Schaughency, Atkins, Murphy, Hynd, Russo, Hartdagen, & Lorys-Vernon, 1988). The DSM-III-R revised the diagnostic category making it unidimensional. The majority of studies of ADHD children found by this author utilize the DSM-III to designate a clinical diagnostic category (Lahey, et al., 1988; Weissman, et al., 1987).

Puig-Antich (1980) indicate that prior to 1976 there had been no mention of affective disorders in child psychiatry textbooks. However, today depressed children are being studied in child psychiatric clinics. The DSM-III-R is a widely accepted and utilized categorical diagnostic system for the study of depressed children (Kovacs, Feinber, Crouse-Novak, Paulauskas, Pollock, & Finkelstein, 1984; Puig-Antich, 1980). "Criterion variance is reduced by the use of the DSM-III's operationally defined diagnoses" (Kovacs et al., 1984, p. 643).

In spite of the wide acceptance of the DSM-III-R as

a valid and reliable diagnostic tool for children some criticism remains (Christensen & Arrington, 1977; Wahler & Dumas, 1987). One question that remains a criticism of the DSM-III-R is whether or not the diagnostic category has any implication for treatment. A second strong criticism of the DSM-III-R is that its diagnostic categories apply only to individuals not to families or interactional pathology.

Although the DSM-III-R is widely used for diagnostic purposes for children, there still remains much work to be done regarding psychiatric diagnoses of childhood disorders. Many deficits exist in child psychiatry including the utilization of adult diagnostic criteria and assessment. Clearly, child psychiatry has advanced considerably from its beginnings; however, much progress is left to be attained.

CHAPTER III

METHODOLOGY

This study investigated parental perceptions of children who had been clinically diagnosed as having an Attention Deficit Hyperactivity Disorder, an Affective Disorder, or a Conduct Disorder. The results of the parents perceptions were assessed in reference to their implications for family therapy.

SPECIFIC NULL HYPOTHESES

1. There will be no significant difference between the scores of mothers and fathers whose child has been clinically diagnosed as conduct disorder on the Conduct Disorder (CD) and Socialized Aggression (SA) scales of the Peterson-Quay Revised Behavior Problem Checklist and the scores of those whose child has been diagnosed as attention deficit hyperactivity disorder or affective disorder.

2. There will be no significant difference between the scores of mothers and fathers whose child has been clinically diagnosed as attention deficit hyperactivity disorder on the Attention Problem-Immaturity (AP) scale

of the Peterson-Quay Revised Behavior Problem Checklist and the scores of those whose child has been diagnosed as either conduct disorder or affective disorder.

3. There will be no significant difference between the scores of mothers and fathers whose child has been diagnosed as affective disorder on the Anxiety Withdrawal (AW) scale of the Peterson-Quay Revised Behavior Problem Checklist and the scores of those whose child has been diagnosed as either conduct disorder or attention deficit hyperactivity disorder.

4. There will be no significant difference in any diagnostic category between the scores of the mothers and fathers on the corresponding scales of the Peterson-Quay Revised Behavior Problem Checklist.

5. There will be no significant correlation in the parents perceptions and any demographic information regarding the parent or child.

DEFINITION OF TERMS

As an assurance against ambiguity, the following terms were defined as indicated for the purpose of this research:

CLINICAL DIAGNOSIS ". . . a common language of mental health clinicians

and researchers for communicating about the disorders for which they have professional responsibility" (Williams & Spitzer, Eds., 1987, p.xviii). Diagnostic criteria are described in the Diagnostic and Statistical Manual of Mental Disorders-Revised (1987).

PERCEPTIONS

The manner in which the parent views the child's behavior as measured by a score on the Peterson-Quay Revised Behavior Problem Checklist (RBPC) (see Appendix C).

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

A disorder defined by the DSM-III-R as having specific diagnostic criteria (see Appendix D).

AFFECTIVE DISORDER

A disorder defined by the DSM-III-R as having specific diagnostic criteria (see Appendix F).

CONDUCT DISORDER

A disorder defined by the DSM-III-R as having specific diagnostic criteria (see Appendix E).

INSTRUMENTATION

The Peterson-Quay Revised Behavior Problem Checklist, the Diagnostic and Statistical Manual of Mental Disorders

third edition revised, and the researchers self-constructed demographic questionnaire were used in this study.

Revised Behavior Problem Checklist

The instrument utilized to assess the parents' perceptions of their child is the Peterson-Quay Revised Behavior Problem Checklist (RBPC). The original Behavior Problem Checklist (BPC) was the outgrowth of a series of factor analytic inquiries into the structure of deviant behavior in children and adolescents which began in 1959. A revising of the BPC was completed in 1980 to strengthen its psychometric characteristics. This revision sought to keep the RBPC in a simple, reasonable length and format.

The RBPC allows rating of 89 problems commonly seen in children and adolescents. Its six subscales, derived from factor analyses, measure conduct disorder, socialized aggression, attention problems-immaturity, anxiety-withdrawal, psychotic behavior, and motor excess. The RBPC has been found useful in educational, mental health, pediatric and correctional settings as well as for research purposes. Ratings can be completed in about 10 minutes. The checklist is brief and easily scoreable.

The RBPC has been determined to have a good

reliability. The six scales have been assessed for intercorrelations. No one scale shared more than 49% of the variance with any other scale with most of the variances ranging from 1% to 20% (Quay & Peterson, 1987). Internal consistency (reliability) was determined for each of the scale on six varying samples with over 1000 ratings. These samples covered the age range from 5 to 23 years. The lowest internal consistency was .68 for the psychotic behavior scale and sample 6 and the highest was .95 for the conduct disorder scale and samples 4 and 5 (Quay & Peterson, 1987). Interrater reliability was significant at the .05 level or better in a normative sample utilizing teachers and another one utilizing parents (Quay & Peterson, 1987). Test-retest reliability for each of the six scales ranged from .49 to .83 (Quay & Peterson, 1987). Concurrent validity was determined to be significant for all but one scale beyond the .01 level (Quay & Peterson, 1987). The concurrent validity of the scales against the dichotomy of clinical versus normal was established. The difference between the means of all six scales of the two groups was found to be substantial. Norms were set for both normal and clinical populations (Quay & Peterson, 1987).

Demographic Questionnaire

A demographic questionnaire designed to assess basic demographic information and some factual information regarding the parents view of the family was utilized. No pilot study was conducted on this questionnaire; however, several practitioners who work regularly with families reviewed the questionnaire and determined that the information being requested was sufficient. Since demographic information is often generic and this study was mainly interested in assessing parental perceptions, general demographics such as age, education, employment status etc., were determined (see Appendix B).

DSM-III-R

The Diagnostic and Statistical Manual for Mental Disorders third edition was revised in 1987. DSM-III has been the mental health practitioners handbook since 1974. Even textbooks which address psychopathology refer extensively to the DSM-III. Since the birth of the DSM-III, numerous articles which have directly addressed some aspect of it have appeared in the professional literature. Because of its quick acceptance in other countries, the DSM-III has been translated into many other languages.

The first DSM appeared in 1952. This first edition contained a glossary of descriptions of diagnostic categories. The DSM-II was developed in 1968 and was based on the same classifications as the International Classification of Diseases. Perhaps the major difference in the DSM-I and DSM-II was that the DSM-II did not employ a specific theoretical framework for understanding mental disorders. The DSM-III appeared in 1974 and was targeted specifically for the United States due to the lack of detail contained in the ICD-9. Numerous advisory committees consulted on the diagnostic categories of the DSM-III; thus, attempting to make it quite comprehensive and detailed. In 1983 a revision of the DSM-III began in an attempt to refine and add knowledge to the classification system in some areas which were lacking sufficient detail. The DSM-III-R contains descriptive information about various diagnostic categories as well as diagnostic criteria.

POPULATION AND SAMPLE

The target population to which this study is generalizable was families of children with Attention Deficit Hyperactivity, Affective, and Conduct Disorder psychiatric diagnoses in the United States. An

experimentally accessible population of children and their parents who sought psychiatric services at local mental health clinics and who were diagnosed to fall into one of the three diagnostic categories was utilized. From this population, a random sample was chosen for each diagnostic category. Each diagnostic category had approximately 50 initial subjects in order to account for attrition. Only school age children under 18 years of age were utilized.

DATA COLLECTION

This was a descriptive research design. Parents score on the RBPC was the dependent variable. Several independent variables were utilized including diagnosis, age, sex, and other demographic information.

Children of parents who sought psychiatric intervention at local mental health centers were given a DSM III-R diagnosis at the initial appointment which is the standard procedure in clinical settings. The therapist making the clinical diagnosis was a licensed practitioner licensed to diagnose in the state of Virginia. If the child fell into one of the diagnostic categories, then several other factors were assessed. The child must also have been living with either both of

his biological parents, with one biological parent and a stepparent who has been a parent to the child prior to his/her 5th birthday, or adoptive parents who adopted the child prior to his/her 5th birthday. This designation controlled for factors that impact with stepparents and older stepchildren. Once both criteria were met, the therapist then asked the client's parents to participate in a study which will aid the therapist in obtaining information which will be of value in his/her helping them to address their current concerns. The therapist knew no further information regarding the study to control for experimenter bias. After completing a consent to participate (see Appendix A), the parents were given an anonymously numbered demographic sheet and Peterson-Quay Revised Behavior Problem Checklist to complete and return to the therapist. Both mother and father were asked to complete the questionnaires separately. Once the questionnaires were completed and the results determined, the therapists were informed and the results given by their clients were shared so they may benefit from the knowledge as well as share the information with their clients. General group perceptions of the parents were also identified. Also, the therapist was given access to the specific ratings of

their client after all results had been tabulated. At no time did the experimenter know which questionnaires belonged to which clients. In order to assure confidentiality only the therapists had access to that information.

DATA ANALYSIS

Due to the descriptive nature of this study, several statistical analyses were used. Initially, frequency analysis was used to ensure that this population resembled expected populations in terms of the distribution of diagnosis by sex, age, etc., i.e., more males were diagnosed attention deficit hyperactivity disorder than females. T-tests were conducted to assess the significance of the RBPC scales within each group for mothers and fathers. Multiple regression analysis was used to investigate which variables (e.g., age, diagnosis, sex of child, parents education) influenced perception.

The primary investigation centered around an examination of parents perceptions of their child's behavior as measured by the RBPC and the match of their perceptions to actual diagnosis.

ETHICAL CONSIDERATIONS

Approval was obtained from the human subjects committee at the College of William and Mary for this study. Approval was also obtained from the directors of the mental health centers utilized. Each parent signed a voluntary participation form prior to their completion of the questionnaires. Anonymous results have been collected with only the participants therapist knowing names and only group results were reported. The participants were informed that we were obtaining information about how they see their child. As such, they were fully informed. Participants were given the right to refuse participation without bias to them or their child. Confidentiality was maintained via anonymous reporting. De-briefing was conducted with the therapists and each client had the opportunity to be de-briefed by either their therapist or this experimenter.

LIMITATIONS OF STUDY

Several limitations to this study existed as a result of the nature of the study. The more salient limitations are addressed below.

Two of the three measures, the RBPC and the demographic information, rely solely on the accuracy of

the informant self-report for valid completion. The examiner relied on the parents report of their perceptions.

Clinical diagnosis, although determined by a trained professional and contingent on the DSM-III-R, still permitted a certain amount of variability. The experimenter was reliant on the professional's interpretation of the DSM-III-R criteria.

Since the children and parents had already sought psychiatric intervention, the subject population may not be generalizable to those populations with the same diagnoses who had not sought psychiatric assistance.

While the Peterson-Quay Revised Behavior Problem Checklist was said to be quite reputable and maintains a reliability and validity appropriate for usage in research, it had not been defined as specifically assessing perceptions.

The community mental health subjects may have varied enough from the parents of these children who seek psychiatric intervention at other facilities that even generalizing to the population of parents sought psychiatric intervention in general may be skewed.

Summary of Methodology

This study was conducted to determine if parents perceptions of their child clinically diagnosed as either conduct disorder, affective disorder, or attention deficit disorder differ from one another. The answer to this was achieved by investigating how parents view their children as indicated by their results on six scales of the Peterson Quay Revised Behavior Problem Checklist and by gathering demographic information about each parent and child.

Questionnaires were distributed to local mental health clinics in the Tidewater area of Virginia. Parents who sought psychiatric intervention for their children were asked to complete the questionnaires if their child had been given a diagnosis of either conduct disorder, affective disorder, or attention deficit disorder. Both parents completed each questionnaire independently of one another. The total sample size was 194. The results of the questionnaires were statistically analyzed with frequency analysis, t-tests, and multiple regression analysis.

CHAPTER IV

RESULTS

The statistical findings of this study are presented in this chapter. The results are organized into two categories. First, a description of the demographics for the total sample and each diagnostic category utilizing frequency analysis is given. Secondly, evaluations of each of the specific null hypotheses are delineated.

This study investigated the perceptions that parents have of their child who had been given a specific clinical diagnosis and the implications those perceptions may have on family therapy. The results were obtained from a demographic questionnaire and the Peterson-Quay Revised Behavior Problem Checklist.

Total Sample Demographics

The total sample consisted of 194 completed questionnaires. Thirty sets of mother-father questionnaires were returned for the conduct disorder diagnosis, 31 sets of questionnaires were returned for the affective disorder diagnosis, and 36 sets of questionnaires were returned for the attention deficit

hyperactivity disorder diagnosis. The total sample consisted of 117 males and 77 females. The age range was 5 years to 17 years with a mean of 10.04 years. The children ranged from kindergarten to twelfth grade with a mean grade of 4.49. These families had from 1 to 6 children with the average having 2.49 children. Eighty-five respondents were biological mothers, 77 were biological fathers, 9 were stepmothers, 19 were stepfathers, 1 was an adoptive mother, and 3 were adoptive fathers.

Educational levels for parents ranged from under 8th grade to graduate school. The mean was slightly above high school completion and below some college or college graduate. The range of the years married was from 1 to 31 years with the average at 11 years. Ninety-seven respondents rated their marriage as happy, 58 rated their marriage as slightly happy, 14 stated their marriage was unhappy, 3 stated their marriage was very unhappy, 21 stated they were very happy, and 1 stated he was perfectly happy; the mean on the marriage ratings was 3.63, a little over half way between slightly happy and happy. The majority, 124 respondents, were employed full time, 15 were employed part time, and 55 were unemployed. Respondent annual incomes ranged from \$0- \$5,000 to

\$45,000-\$50,000. The mean income was slightly above the \$15,000-\$20,000 dollar range.

The age at which each parent had the targeted child for this study ranged from 16 to 39 with the mean being 24.03 years. Ratings of how the parent saw their child during infancy ranged from very difficult to very easy with the mean being 2.99 or right at normal. The level of stress the respondents felt during their child's first three years ranged from 0 to 10 with 0 being no stress and 10 being exceptional stress; the mean was 5.38. The amount of time spent weekly with the child ranged from 0-5 hours to more than 20 hours with the mean being 2.51 or between 5-10 hours and 10-15 hours. The age at which the respondents first recognized a problem in their child ranged from infancy to 17 years; the mean was 6.26 years old.

Information pertaining to actual participation in therapy is described below. Ninety-four of the respondents were referred to the therapist by the school system, 29 were referred by their mothers, 15 were referred by the intake worker at the managed health care facility for military dependents, 11 were referred by Social Services, 8 were referred by their medical doctor and 8 were referred by their fathers, 7 were referred by

their probation officer, 4 were referred by their counselor at school and 4 were referred by the hospital. The following referral sources referred one or two of the respondents: court, pastor, lawyer, psychologist, friend, school psychologist, and Navy Family Service Center. One hundred and twenty-two of the respondents indicated that mother drove the child to therapy, 30 indicated that father drove the child to therapy, 29 stated that both parents drove the child, 5 indicated that the child drove themselves to therapy, 4 indicated that a friend drove them, and 2 stated that a social worker drove them. The respondents willingness to participate in treatment was rated on a 0 to 10 scale with 0 being unwilling and 10 being completely willing; the mean for the total sample was 8.19.

Demographic Results by Diagnostic Group

Conduct Disorder

The Conduct Disorder group had a sample of 30 sets of mother-father questionnaires completed and returned. The mean age of the children given this diagnosis was 11.5 years with the range being 5 to 17 years. There were 42 males and 18 females in the sample. The grades ranged from 1 to 11 and the mean was 5.42. The mean

number of children in the family was 2.6. Twenty-eight biological mothers and 24 biological fathers completed the questionnaires as did 1 stepmother, 6 stepfathers, and 1 adoptive father. The mean educational level of the parents in this group was the same as that of the total sample, between high school and some college. The average length of the parents marriage was 12.27 years. The parents mean ratings of their marriage was 3.63 which is between slightly happy and happy. Forty of the respondents in this group were employed full time, 15 were not employed, and 5 were employed part time. The mean income of this group was 4.3 or between \$15,000 and \$25,000. The average age of the parent when the child entered into their life was 24.65 years.

The parents in this group described their child as being between slightly difficult and normal with a mean of 2.86. The mean level of stress these parents experienced during their child's first three years was 5.85. With an average of 2.21 these parents spent between 5 to 10 and 10 to 15 hours weekly with their child. These parents noted a problem with their child at about the age of 6.15 years. By a majority the school was the referral source and by the majority the mothers drove these children to therapy. The mean willingness of these

parents to be involved in therapy was 7.53.

Affective Disorder

The affective disorder group had 31 sets of mother-father questionnaires completed and returned resulting in a sample of 62. The children given this diagnosis had a mean age of 10.36 years. There were 26 males and 36 females in this diagnostic group. The average grade was 4.98 and the mean number of children in the family was 2.76. The majority of the parents were biological mothers (26) and biological fathers (23). There were 4 stepmothers, 7 stepfathers, 1 adoptive mother, and 1 adoptive father. The mean educational level of these parents was 2.39 or between completion of high school and some college. The average number of years these parents had been married was 10.77. The mean ratings of their marriages was 3.51 or between slightly happy and happy. Thirty-five parents were employed full time, 5 were employed part time, and 19 were not employed. The mean income level for this group was 4.58 or between \$15,000 to \$20,000 and \$20,000 to \$25,000 annually. The mean age of these parents when the child entered into their life was 23.71 years. These parents indicated that their child was slightly above normal (\bar{M} = 3.21) in comparing

their child to other children. On a scale of 0 to 10, the average level of stress these parents experienced during their child's first three years was 5.19. The average time that this group of parents spent with their children was 2.73 or between 5 to 10 and 10 to 15 hours per week. The mean age at which these parents first noticed a problem with their child was 7.16 years. By far, the school made the most referrals in this group (23) with mothers making the second most referrals (11). Mothers of this group also drove the children to therapy most often (31). With fathers and both parents driving at 11 each. The mean level of willingness of these parents to be involved in treatment was 8.45 on a scale of 0 to 10.

Attention Deficit Hyperactivity Disorder

The sample for this diagnostic group consisted of 36 sets of mother-father completed questionnaires resulting in a sample size of 72. The average age of children in this sample was 8.89 years. There were 49 males and 23 females in the sample. The children's average grade was 3.28. The mean number of children in these families was 2.18. This sample had 31 biological mothers and 30 biological fathers, 4 stepmothers and 6 stepfathers, and

1 adoptive father. The mean educational level of the parents was 2.39 or between completion of high school and some college. The average length of time married for these parents was 10.15 years. The mean rating of their marriages was 3.72 or between slightly happy and happy.

Forty-six of the respondents were employed full time, 5 were employed part time, and 21 were not employed. The average income level of this group was 4.36 or between \$15,00 to \$20,000 and \$20,000 to \$25,000 annually. The average age at which this parent entered into their child's life was 23.93 years. This group described their child on the average ($\bar{M}=2.09$) as normal compared to other children. The mean level of stress these parents experienced during their child's first three years was 5.14 on a scale of 0 to 10. The average length of time these parents spent with their child weekly was 2.57 or between 5 to 10 and 10 to 15 hours. The average age of onset of the problem as viewed by these parents was 5.58 years. By the majority, 41 children were referred by the school system and 10 were referred by their mothers. Other referral sources included court, Social Services, fathers, school psychologist, Navy Family Services, friends, psychologist, and probation officer. Mothers drove the

child to therapy by the majority (52), 11 stated that both parents drove the child to therapy, and 8 stated that fathers drove the child to treatment. The willingness of these parents to be involved in treatment averaged 8.51 on a scale of 0 to 10.

Evaluation of the Null Hypotheses

In order to assess statistically significant differences between the scores of parents on each of the six scales of the Peterson Quay Revised Behavior Problem Checklist frequency analysis and t-tests analysis were conducted on each scale for each diagnostic group. These analyses address the first four hypotheses of this study. Multiple regression analyses were conducted to assess the variables which significantly predict diagnosis and each scale of the RBPC. These analyses address the last two hypotheses of this study.

Null Hypothesis I-1

There will be no significant difference between the scores of parents whose child has been clinically diagnosed as conduct disorder on the Conduct Disorder (CD) and Socialized Aggression (SA) scales of the RBPC and those whose child has been diagnosed as affective

disorder.

Results

On the Conduct Disorder (CD) scale of the RBPC, parents of conduct disorder subjects rated their children significantly higher than did parents of affective disorder children (see Table 1) ($t_{[120]} = 5.42, p < .0001$). On the Socialized Aggression (SA) scale, there was a significant difference in the ratings of parents of conduct disorder and affective disorder children (see Table 1) ($t_{[120]} = 3.78, p < .0001$).

 Insert Table 1 About Here

Null Hypothesis 1-2

There will be no significant difference between the scores of parents whose child has been clinically diagnosed as conduct disorder on the Conduct Disorder (CD) and Socialized Aggression (SA) scales of the RBPC and those whose child has been diagnosed as attention deficit hyperactivity disorder.

Results

On the Conduct Disorder (CD) scale of the RBPC, parents of the conduct disorder subjects rated their children significantly higher than did parents of

attention deficit hyperactivity disorder children (see Table 1) ($t_{[130]} = 4.94, p < .0001$). On the Socialized Aggression (SA) scale, there was a significant difference in the ratings of parents of conduct disorder and attention deficit hyperactivity disorder children (see Table 1) ($t_{[130]} = 4.34, p < .0001$).

Null Hypothesis II-1

There will be no significant difference between the scores of parents whose child has been clinically diagnosed as attention deficit hyperactivity disorder on the Attention Problem-Immaturity (AP) scale of the RBPC and the scores of those whose child has been diagnosed as conduct disorder.

Results

On the Attention Problem-Immaturity (AP) scale of the RBPC, parents of attention deficit hyperactivity disorder subjects did not rate their children significantly higher than did parents of conduct disorder children (see Table 1) ($t_{[130]} = -0.71, p = 0.495$).

Null Hypothesis II-2

There will be no significant difference between the scores of parents whose child has been clinically

diagnosed as attention deficit hyperactivity disorder on the Attention Problem-Immaturity (AP) scale of the RBPC and the scores of those whose child has been diagnosed as affective disorder.

Results

On the Attention Problem-Immaturity scale of the RBPC, parents of attention deficit hyperactivity disorder subjects rated their children higher than did parents of affective disorder children (see Table 1) ($t_{[132]} = -3.81, p < .0001$).

Null Hypothesis III-1

There will be no significant difference between the scores of parents whose child has been clinically diagnosed as affective disorder on the Anxiety-Withdrawal (AW) scale of the RBPC and the scores of those whose child has been diagnosed as conduct disorder.

Results

On the Anxiety-Withdrawal (AW) scale of the RBPC, parents of affective disorder subjects rated their children significantly higher than did parents of conduct disorder children (see Table 1) ($t_{[120]} = -3.48, p = .001$).

Null Hypothesis III-2

There will be no significant difference between the scores of parents whose child has been clinically diagnosed as affective disorder on the Anxiety-Withdrawal (AW) scale of the RBPC and the scores of those whose child has been diagnosed as attention deficit hyperactivity disorder.

Results

On the Anxiety-Withdrawal (AW) scale of the RBPC, parents of affective disorder subjects rated their children significantly higher than parents of the attention deficit hyperactivity disorder children (see Table 1) ($t_{[132]} = 6.51, p < .0001$).

Null Hypothesis IV

There will be no significant difference in any diagnostic category between the scores of the mothers and fathers on the corresponding scales of the RBPC.

Results

On the Conduct Disorder (CD) scale of the RBPC, mothers and fathers of conduct disorder subjects showed a significant difference in their ratings of their children (see Table 2) ($t_{[58]} = 2.35, p < .05$). The mothers and fathers of affective disorder children did not show a

significant difference in their ratings of their children on the Conduct Disorder (CD) scale of the RBPC (see Table 2) ($t_{[60]} = 0.67, p = 0.51$). On the Conduct Disorder (CD) scale of the RBPC, mothers and fathers of attention deficit hyperactivity children showed a significant difference (see Table 2) ($t_{[70]} = 3.19, p < .01$).

Insert Table 2 About Here

On the Socialized Aggression (SA) scale of the RBPC, mothers and fathers ratings of their conduct disordered children did not show a significant difference (see Table 2) ($t_{[58]} = 1.18, p = 0.24$). The mother's and father's ratings of affective disorder children on the Socialized Aggression (SA) scale did not show a significant difference (see Table 2) ($t_{[60]} = -0.22, p = 0.83$). On the Socialized Aggression (SA) scale of the RBPC, mothers and fathers of attention deficit hyperactivity subjects did not rate themselves significantly different (see Table 2) ($t_{[70]} = 0.53, p = 0.60$).

On the Attention Problem-Immaturity (AP) scale of the RBPC, the mothers and fathers of conduct disorder children showed a significant difference (see Table 2) ($t_{[58]} = 2.31, p < .05$). The mothers and fathers of

TABLE 1

	<u>CD</u>	<u>AFFECTIVE</u>	<u>ADHD</u>
CD	50.72	45.37	45.79
SA	53.10	47.71	47.04
AP	46.42	43.63	47.10
AW	43.93	48.34	41.74
PB	50.57	46.31	46.33
ME	48.63	46.10	49.63

GROUPS : CD= conduct disorder group

AFFECTIVE= affective disorder group

ADHD= attention deficit hyperactivity group

RBPC Scales: CD= conduct disorder

SA= socialized aggression

AP= attention problem-immaturity

AW= avoidance-withdrawal

PB= psychotic behavior

ME= motor excess

disorder children did not rate their children significantly different on the Attention Problem-Immaturity (AP) scale of the RBPC (see Table 2) ($t_{[60]} = 0.48$, $p = 0.63$). On the Attention Problem-Immaturity (AP) scale of the RBPC, mothers and fathers of attention deficit hyperactivity disorder children rated their children significantly different (see Table 2) ($t_{[70]} = 3.29$, $p < .01$).

On the Anxiety-Withdrawal (AW) scale of the RBPC, mothers and fathers of conduct disorder children did not rate their children significantly different (see Table 2) ($t_{[58]} = 1.67$, $p = 0.10$). On the Anxiety-Withdrawal (AW) scale of the RBPC, mothers and fathers of affective disorder children did not rate their children as significantly different (see Table 2) ($t_{[60]} = 1.63$, $p = 0.11$). The mothers and fathers of attention deficit hyperactivity disorder children rated their children significantly different on the Anxiety-Withdrawal (AW) scale of the RBPC (see Table 2) ($t_{[70]} = 4.09$, $p < .0001$).

On the Psychotic Behavior (PB) scale of the RBPC, mothers and fathers of conduct disorder children did not rate their children significantly different (see Table 2) ($t_{[58]} = 1.56$, $p = 0.13$). Mothers and fathers of affective disorder children did not rate their children

significantly different on the Psychotic Behavior (PB) scale of the RBPC (see Table 2) ($t_{[60]} = 0.71, p = 0.48$). On the Psychotic Behavior (PB) scale of the RBPC, mothers and fathers of attention deficit hyperactivity disorder rated their children significantly different (see Table 2) ($t_{[70]} = 2.43, p < .05$).

On the Motor Excess (ME) scale of the RBPC, mothers and fathers of conduct disorder children did not rate their children significantly different (see Table 2) ($t_{[58]} = 1.58, p = 0.12$). Mothers and fathers of affective disorder children did not rate their children significantly different on the Motor Excess (ME) scale of the RBPC (see Table 2) ($t_{[60]} = 0.34, p = 0.73$). On the Motor Excess (ME) scale of the RBPC, mothers and fathers of attention deficit hyperactivity disorder did not rate their children significantly different (see Table 2) ($t_{[70]} = 1.84, p = 0.07$).

Null Hypothesis V

There will be no significant correlation in the parents perceptions and any demographic information regarding the parent or child.

Results

When the RBPC scales were regressed against

Table 2

	<u>CD</u>		<u>AD</u>		<u>ADHD</u>	
	1	2	1	2	1	2
CD	52.30	49.13	45.84	44.90	47.89	43.69
SA	54.43	51.77	47.52	47.90	47.50	46.58
AP	48.30	44.53	44.00	43.26	48.72	45.47
AW	45.73	42.13	49.39	47.29	44.53	38.94
PB	52.27	48.87	46.81	45.81	48.03	44.64
ME	49.97	47.30	46.45	45.87	51.00	48.25

1= mothers 2= fathers

GROUPS: CD= conduct disorder

AFFECTIVE= affective disorder

ADHD= attention deficit hyperactivity disorder

RBPC Scales: CD= conduct disorder

SA= socialized aggression

AP= attention problem-immaturity

AW= avoidance-withdrawal

PB= psychotic behavior

ME= motor excess

diagnosis, only Conduct Disorder (CD), Attention Problem-Immaturity (AP), and Socialized Aggression (SA) emerged as significant predictor variables ($p < .05$). With these three scales as predictors, $R = .25$. When the demographic information was regressed against diagnosis, the child's age, parents willingness to participate in treatment, and the stress the parent felt during the child's first three years emerged as significant predictor variables ($p < .05$). With these three variables as predictors, $R^2 = .12$.

When the scales of the demographic variables were regressed against the Conduct Disorder (CD) scale of the RBPC, the stress the parent felt during the child's first three years, the child's age, the age at which the parent recognized the problem, and the child's sex emerged as significant predictor variables ($p < .05$). With these four variables as predictors, $R^2 = .15$.

When the demographic variables were regressed against the Socialized Aggression (SA) scale of the RBPC, the child's age, and the age at which the parents recognized a problem emerged as significant predictor variables ($p < .05$). With these two variables as predictors, $R^2 = .24$.

When the demographic variables were regressed against the Attention Problem-Immaturity (AP) scale of

the RBPC, the parents socioeconomic status, the age the parents recognized the problem, the child's age, the willingness of the parents to participate in treatment, and the child's sex emerged as significant predictor variables ($p < .05$). With these five variables as predictors, $R^2 = .16$.

When the demographic variables were regressed against the Anxiety-Withdrawal (AW) scale of the RBPC, amount of time spent with the child weekly, the child's age, the parents level of education, and the child's sex emerged as significant predictor variables ($p < .05$). With these four variables as predictors, $R^2 = .21$.

When the demographic variables were regressed against the Psychotic Behavior (PB) scale of the RBPC, the amount of stress the parents experienced in the child's first three years, the child's age, and the age at which the parents recognized a problem emerged as significant predictor variables ($p < .05$). With these three variables as predictors, $R^2 = .12$.

When the demographic variables were regressed against the Motor Excess (ME) scale of the RBPC, the child's sex, and the age at which the parent recognized a problem emerged as significant predictor variables ($p < .05$). With these two predictor variables, $R^2 = .09$.

Summary of Results

One hundred ninety-four questionnaires were completed and returned to the experimenter. Three diagnostic categories were utilized with 60 questionnaires being returned for the conduct disorder group, 62 for the affective disorder group, and 66 for the attention deficit hyperactivity group. Demographic information was collected and analyzed with frequency analyses. Parental perceptions were assessed via the parents responses to the eighty-nine item Peterson Quay Revised Behavior Problem Checklist. Means, ranges, and standard deviations were determined for each item on the RBPC as well as each demographic item. T-tests were conducted on the six scales of the RBPC to assess any significant difference between mothers and fathers perceptions on each of the scales.

Multiple regression analyses were conducted on the demographic information and the six scales of the RBPC first utilizing diagnosis as the dependent variable. Then, multiple regression analyses were conducted on the demographic items with each of the six scales of the RBPC as the dependent variable. This assessed what demographic items contributed significantly to each scale on the RBPC.

The hypotheses were addressed in terms of the results of each statistical procedure conducted and the results are listed in Tables within this chapter.

CHAPTER V

SUMMARY, CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

This chapter presents a summary of the research. Conclusions based on the results of the statistical analyses conducted on the data are also presented. In addition a discussion of the implications these conclusions have for family therapy is provided. Finally, recommendations for future research are offered.

SUMMARY

Existing research on parental perceptions of children is limited at best. A significant amount of research is available on family systems and the importance families have in our lives, yet noticeably lacking is research that provides even descriptive data on parents' perceptions of their children and the impact those perceptions have on the family. The research that does exist centers around mother's interactions and perceptions of their children excluding fathers and the roles they play in interacting with their children. In addition, the existing research focuses on parent's personality characteristics as the main factor in parent's interaction with their children.

Much of the family therapy literature directly supports the inclusion in and expansion of research related to children. Still, even family therapists have limited their research on parental perceptions of children.

This study was derived from the obvious deficit in literature pertaining to children and the perceptions their parents have of them. Since families are the primary system in which children interact and individual interactions are generally based on perceptions, Coyne's theory of interaction was utilized as the basis of this study.

Children who arrive in mental health clinics often do so because someone in their world has identified them as a "problem". This research investigated the differences, if any, between mother's and father's perceptions of the child who had been given a clinical diagnosis of conduct disorder, affective disorder, or attention deficit hyperactivity disorder. Fathers were included in this study since information regarding father's perceptions and interactions with their children was virtually non-existent in the literature. While most therapeutic interventions would provide supportive therapy for parents with a difficult child, many do not

address the significance that the parents perceptions may have on treatment. Differences between mother's and father's perceptions of their children is a critical issue to the usage of family therapy in providing adequate and beneficial intervention for these children and their families.

Based on the lack of previous research, this study began with the very basics in addressing the issue of parental perceptions: descriptive data regarding the way mothers and fathers view their children, and assessment of any differences between parents' perceptions for a specific child and across three specific diagnostic categories. The instruments utilized to assess information regarding the subjects and their parents and parental perceptions were a demographic questionnaire designed by the experimenter and the Peterson Quay Revised Behavior Problem Checklist.

The sample of the population used in this study was 194 parents who completed both the demographic questionnaire and the Peterson Quay Revised Behavior Problem Checklist. Each of the three diagnostic categories had at least 30 sets of mother-father questionnaires returned. Clinicians licensed to diagnosis in the state of Virginia made the designation

as to which diagnostic category each subject was placed.

This was a descriptive research design with data being collected from both a demographic questionnaire (Appendix B) and the six scales of the Peterson Quay Revised Behavior Problem Checklist (Appendix C). The data obtained was investigated utilizing several statistical analyses including: frequency analyses, T-tests, and multiple regression analyses. A significance level of .05 was chosen for rejection of the null hypothesis.

CONCLUSIONS

The results of this study indicate several significant differences between parent's perceptions on the six scales of the Peterson Quay Revised Behavior Problem Checklist (RBPC). There was a significant difference between parent's perceptions of children diagnosed with conduct disorder on the Conduct Disorder (CD) scale of the RBPC and parents whose child was diagnosed as affective disorder or attention deficit hyperactivity disorder. On the Socialized Aggression (SA) scale of the RBPC, parents of conduct disorder children rated their children significantly higher than parents of affective disorder and attention deficit

hyperactivity disorder children. On the Attention Problem-Immaturity (AP) scale of the RBPC parents of attention deficit hyperactivity disorder children did not rate their children differently from parents of conduct disorder children; however, the parents of attention deficit hyperactivity disorder children did rate their children significantly higher than the parents of affective disorder children.

On the Anxiety-Withdrawal (AW) scale of the RBPC, parents of affective disorder children did rate their children significantly higher than did parents of conduct disorder or attention deficit hyperactivity disorder children.

These data, then, would suggest that parents accurately perceive conduct disorder children as higher on behaviors associated with acting-out, disregard of others rights, etc. Contrary to what might have been anticipated, parents of attention deficit hyperactivity disorder children did not misinterpret their child's hyperactivity as being a conduct problem. As expected, parents of affective disorder children recognized that their child was more withdrawn than either conduct or attention deficit hyperactivity disorder children. This data validate anxiety and withdrawal as key factors in

depression, but indicate they may be far less important in conduct or attention deficit problems.

There were some significant differences between mother's and father's perceptions of their children in each diagnostic category. For the conduct disorder children mothers rated their children significantly higher on the Conduct Disorder (CD), and the Attention Problem-Immaturity (AP) scales of the RBPC. That is, fathers were less likely to perceive acting-out behaviors as being as serious as mothers perceived them. Likewise, fathers of conduct disorder children were less likely to see attention deficit and immaturity as a problem. These data are consistent with stereotypic notions that father's perceive their child's behavior as less severe and that they are generally more tolerant than mothers of a wide range of behaviors. Mothers and fathers did not show a significant difference in their ratings for the other four scales of the RBPC.

There was no significant difference in parent's perceptions on any of the scales of the RBPC for affective disorder children.

For attention deficit hyperactivity disorder children, significant differences in parent's perceptions were reported for the Conduct Disorder (CD), Attention

Problems-Immaturity (AP), Anxiety-Withdrawal (AW), and Psychotic Behavior (PB) scales with mothers appearing more sensitive to acting-out, arguing and quarreling, poor attention span, sloppy schoolwork, depression, withdrawal, and expressing strange beliefs on the part of their child.

When utilizing the child's diagnosis as the dependent variable the following items, in order of their significance of prediction, were found to predict diagnosis: the Conduct Disorder (CD) scale of the RBPC, the Attention Problem-Immaturity (AP) scale of the RBPC, the Socialized Aggression (SA) of the RBPC, the willingness of the parent to participate in treatment, the Anxiety-Withdrawal (AW) scale of the RBPC, and the child's age.

When demographic variables were examined, the age of the child and the age at which the parents first noticed the problem were consistent significant variables across diagnostic categories in relation to the RBPC scales. The attention deficit hyperactivity children had the earliest age of onset followed by the conduct disorder children and the affective disorder children. This would suggest that either attention deficit hyperactivity problems are being recognized and diagnosed earlier or

that children do indeed develop these problems at a much earlier age than they develop conduct disorders or depression. The age of onset for all three diagnostic categories generally corresponds with data in the current literature as well as with generally accepted clinical impressions.

This research indicates that, at least for children with conduct disorder, affective disorder, or attention deficit hyperactivity disorder diagnoses, males are more predominant clients in mental health clinics than females. However, as the literature supports, more females in this sample were diagnosed with affective disorder than males. Both the conduct disorder and attention deficit hyperactivity disorder groups had far more male subjects. The conduct disorder children tended to be older than the other two groups. Grade levels for each of the three diagnostic groups varied with the attention deficit hyperactivity disorder group being the youngest, affective disorder next, and conduct disorder being the oldest.

The conduct disorder group parents had a longer length of marriage than the other two groups possibly correlating with the older age of the child. Also, the parents in this group seemed to feel more stress during

their child's first three years of life than the other two groups. The parents in the conduct disorder group on a whole were less willing to be involved in treatment than the parents of the other two groups.

This research indicates that there are indeed specific differences between parent's perceptions of their children across three diagnostic categories and between mother and father dyads. Significant differences exist between specific scales of the RBPC as well as on certain demographic categories.

DISCUSSION

The research abounds with information on family therapy and the importance of involving the family in treatment of psychiatric disorders with children; however, virtually nonexistent is the literature pertaining to parental perceptions and the role they have in treatment. Thus, this study assessing the nature of parents perceptions of their child and how they differ is a much needed step in providing better mental health care for children.

Professionals who provide psychiatric evaluation, treatment, and recommendations for children must have access to as much information as possible regarding the

environments in which these children live and learn. Families are a key component of any child's life; therefore, it stands to reason that any professional involved with the child would benefit from as much knowledge about the child's family as is available. The literature indicates that perhaps the most effective mode of intervention with children is family therapy. Observing and understanding the parent's interactions with the child are critical to the effectiveness of family therapy. Interactions between various members in a system such as the family are contingent upon the family members perceptions of one another and their situation.

This research provides descriptive data regarding parent's perceptions of their child. Although parent's perceptions did not show a statistically significant difference on all scales of the Peterson-Quay Revised Behavior Checklist and parents did not show a statistically significant difference on all variables on the demographic questionnaire, this study serves as a starting point for research on parent's perceptions. In each diagnostic group, the Peterson-Quay Revised Behavior Problem Checklist scales which proved statistically significant may offer some credibility to the instrument

as they typify the DSM III-R representations that Peterson and Quay outline in their manual. It is possible that the lack of statistically significant differences on several of the scales exists because of the Peterson-Quay Revised Behavior Checklist subscale intercorrelations. While there were several RPBC scales on which mothers and fathers showed significant differences not all scales in each diagnostic category were significantly different. The affective disorder group showed no significant differences between mothers and fathers on any scale of the RPBC; thus indicating mothers and fathers, in this sample, showed no differences in their perceptions of their affective disorder child.

Important statistics gathered utilizing multiple regression analyses on the child's diagnosis and each scale of the RBPC provide us once again with information which correlates to the internal and external factors contributing to each scale outlined by Peterson and Quay. In this study, the regression analyses utilizing diagnosis as the dependent variable indicated that the significant predictor variables of the Conduct Disorder (CD), Attention Problem-Immaturity (AP), and Socialized Aggression (SA) scales accounted for only 25% of the

variance. The demographic information accounted for an additional 12% of the variance. When the child's diagnosis was regressed against the RBPC scales and the demographic information, 63% of the variance is left unaccounted for. When the demographic information was regressed against the six scales of the RBPC, the greatest amount of variance accounted for was on the Socialized Aggression (SA) scale of the RBPC where the predictor variables accounted for 24% of the variance.

Many of the mental health clinics and practices in Tidewater, Virginia were accessed for subjects which met the criteria and over eighty sets of questionnaires in each diagnostic category were distributed to area mental health professionals. The sample size for each group remained around 30 sets or 60. The difficulty of accessing intact families appeared to be the most hindering factor in this study. This was further complicated by many parents unwillingness to complete questionnaires about their child or one parent's lack of interest or involvement in therapy. The difficulty in accessing intact families may contribute to the lack of documented research on parental perceptions of children.

The mental health professionals who diagnosed these children appear to have adequately placed the child in

the correct diagnostic group as evidenced by group characteristics which correlate with existing literature i.e., more males are diagnosed attention deficit hyperactivity and conduct disorder than females. Other information regarding characteristics of each diagnostic group also validated prior research and clinical suspicions ie., the conduct disorder group had a larger mean age than that of the other groups; the attention deficit hyperactivity group had a lower mean age which correlated with the first one to two years in school. Perhaps the lower mean age for the attention deficit hyperactivity group indicates that parents, school systems and professionals are assessing children earlier and are doing a much better job of early detection of this particular problem.

Mother's and father's perceptions differed significantly on the scales of the Peterson-Quay Revised Behavior Checklist which generally included observable behavioral factors. Therefore, it seems clear that while both parent's perceptions may be highly weighted by the child's behavior, that mothers and fathers perceive those behaviors differently. The means of the mother's scores on each of the scales of the Peterson-Quay Revised Behavior Checklist which proved significant were greater

than the means of the father's scores on the respective scales.

In this study, the parent's willingness to be involved in treatment was the fourth highest correlation with the child's diagnosis. This fact has significant implications for family therapy being the preferred mode of treatment for children with any of the three diagnoses utilized in this study. The age of the child at the time the parents first noticed a problem rated as a significant predictor on five out of six of the scales of the Peterson-Quay Revised Behavior Problem Checklist. The age at which the problem was first noticed by the parents can lead a professional to explore and understand the family dynamics at that time. Other demographic factors that predict the scales on which there were significant differences between mother's and father's scores include: stress the parent felt in the child's first three years, child's age, child's sex, parents willingness to participate in treatment, the parents socioeconomic status, the amount of time spent weekly with the child, and the education of the parents. All of these factors can be influential in conducting family therapy with children and their families. The one demographic category that did not show any validity in

predicting parent's perceptions was the parents rating of their marriage. The literature on family therapy, particularly structural family therapy, indicates that the functioning of the marital dyad may be an important indicator of family and individual functioning.

Certainly any differences in parent's perceptions of their child warrants addressing. Seemingly, via literature and clinical effectiveness, the most appropriate mode of addressing these differences is family therapy. In summary, this research appears to have been beneficial. This study suggests that indeed there are differences in mother's and father's perceptions of their child within three diagnostic categories with the attention deficit hyperactivity disorder group showing more significant differences in parent's perceptions, the conduct disorder group second with numbers of differences, and the affective disorder group showing no significant differences between mother's and father's perceptions. This study of parent's perceptions seems to be a productive endeavor providing information which may be valuable in working with children and their families. This research provides foundational information for continuation of the much needed work on parents perceptions. The research on the

differences in parent's perceptions of their child is so limited that almost any study in this area would provide valuable knowledge.

RECOMMENDATIONS FOR FUTURE RESEARCH

Resulting from this study are several recommendations which are offered for consideration for future research. First, although the sample of 30 sets of questionnaires in each diagnostic category met the criteria for usage of parametric statistical analysis a larger sample would lend more credibility to the study and represent a more normal distribution.

Second, this research utilizes intact families which seem to be a dying breed in our society. A larger sample could be obtained if the influence of this variable could be controlled for and the population be expanded to include divorced, separated, and single parents.

Third, the issue of self rater reliability certainly contributes to the results of this study since only one instrument was utilized to measure perception. Utilization of a variety of other instruments which may measure parent's perceptions including observation, or

other established scales may address this concern. With the descriptive data this study provides, development of a scale which more closely measures parents perceptions may be possible.

Fourth, although this study is beneficial it is just a beginning. More empirical research on parents perceptions would further benefit those professionals who work with children and their families. Specifically, assessing other variables which may contribute to greater variance in the prediction of the child's diagnosis and the scales of the RBPC.

Fifth, this study could be replicated with several other populations to assess for generalizability. Private psychiatric clinics, inpatient psychiatric programs, special education classrooms could all be used. Even utilization of a normal population to assess parents perceptions would provide useful information to therapists in setting appropriate goals for families.

Six, reassessment of the parents perceptions of their child after six months or a year of therapy might reveal changes and provide information regarding the effectiveness of treatment. Also, reassessment of parents perceptions following an interval of various modes of treatment i.e., family therapy, individual

therapy etc. may provide valuable information regarding treatment modality effectiveness and appropriateness.

APPENDIX A

Parental Participation Consent Form

PARENTAL PARTICIPATION CONSENT FORM

This consent form is to request your voluntary participation in a study to be conducted by Pamela Vaught in partial fulfillment of the requirements for the doctoral degree at the College of William and Mary. Please read the following carefully and sign the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate in this study.

The attached checklist and demographic sheet are data to be collected for a doctoral dissertation assessing the way parents view their children. Ultimately, this information will provide important facts about how parents and children interact with one another. Your participation in this study by answering the attached questions will aid your therapist in helping your family.

All data collected in this study will be kept in confidence. Only group data will be reported. You should understand that you may refuse to participate at any time without prejudice to you or your child.

If you have any questions or concerns you may contact one or both of the following people:

Dr. Michael Politano
Licensed Clinical Child Psychologist
School Of Education
College of William and Mary
Williamsburg, VA 23518
(804) 253-4300

or Pamela McComas
Vaught
Licensed
Professional
Counselor,
National
Certified
Counselor
7400 Granby
Street
Norfolk, VA
23505
(804) 587-4700
or 471-7666

Informed and Voluntary Consent to Participate

I have been informed and agree to participate in the study outlined above. My right to decline to participate or to withdraw at any time has been guaranteed.

RESPONSIBLE PARTY (father)

DATE

RESPONSIBLE PARTY (mother)

DATE

APPENDIX B
Demographic Information

DEMOGRAPHIC INFORMATION

CHILDS AGE: _____ CHILDS SEX: _____

CHILDS GRADE IN SCHOOL: _____

NUMBER OF CHILDREN IN THE FAMILY: _____

AGES OF OTHER CHILDREN: _____

WHAT IS YOUR RELATIONSHIP TO THE CHILD:

____ biological mother ____ stepmother ____ adoptive
 mother
____ biological father ____ stepfather ____ adoptive
 father

If step-parent, at what age did you enter into the childs
life? _____

EDUCATIONAL LEVEL OF PARENT: _____ 8th grade or less
____ 9th to 12th grade ____ some college or college
graduate ____ some graduate school or graduate degree

HOW LONG HAVE YOU AND YOUR SPOUSE BEEN MARRIED?

HOW WOULD YOU RATE YOUR MARRIAGE:

____ very unhappy ____ unhappy ____ slightly happy ____ happy
____ very happy ____ perfectly happy

EMPLOYMENT STATUS: ____ not employed ____ part time
____ fulltime

WHAT IS YOUR ANNUAL INCOME?

____ 0-5000	____ 5000-10000	____ 10000-15000
____ 15000-20000	____ 20000-25000	____ 25000-30000
____ 30000-35000	____ 35000-40000	____ 40000-45000
____ 45000-50000	____ above 50000	

AT WHAT AGE DID YOU HAVE THIS CHILD? _____

HOW WAS YOUR CHILD AS AN INFANT COMPARED TO OTHER CHILDREN:

_____very difficult _____slightly difficult
 _____normal _____slightly easy _____very easy

RATE YOURSELF ON THE LEVEL OF STRESS YOU EXPERIENCED DURING YOUR CHILDS FIRST 3 YEARS:

0 1 2 3 4 5 6 7 8 9 10

HOW MUCH TIME DO YOU NORMALLY SPEND WITH YOUR CHILD WEEKLY?

_____ 0-5 hours _____ 5-10 hours _____ 10-15 hours
 _____ 15 to 20 hours _____ more than 20 hours

HOW OLD WAS YOUR CHILD WHEN YOU FIRST RECOGNIZED A PROBLEM? _____

WHO SUGGESTED YOU CONTACT THIS AGENCY?

WHO DRIVES THE CHILD TO THERAPY?

HOW WILLING ARE YOU TO BE INVOLVED IN THERAPY? (0 none-

10 very)

0 1 2 3 4 5 6 7 8 9 10

APPENDIX C

Peterson Quay Revised Behavior Problem Checklist

3829 Buchanan Drive
Virginia Beach, VA
23456
September 12, 1988

Herbert C. Quay, PhD
Box 248074
University of Miami
Coral Gables, Florida 33124

Dear Dr. Quay:

I am a doctoral student at the College of William and Mary in Williamsburg, Virginia and am currently designing my doctoral dissertation.

As a Licensed Professional Counselor, I have a clinical practice which places me in daily contact with children and their parents. Many of these parents express concerns regarding their child's behavior. Often these behavioral dysfunctions are seen in terms of a "problem" within the child. As a family therapist, my goal in therapy is generally to reframe the problem as being one of the family or a family interactional problem.

In the study that I am conducting, I will look at parental perceptions of children who have been diagnosed as having an attention deficit disorder, an affective disorder, or a conduct disorder.

Since I have been unable to locate an instrument which specifically measures parents' perceptions of their children, I would like to request your permission to use your Revised Behavior Problem Checklist as a measure of parents' ratings of their children. I have found it to be the most comprehensive measure of children's behavior. Also, if necessary, I would appreciate any information on purchasing this checklist for usage. Any current research information such as reliability and validity or other studies conducted utilizing this instrument would be much appreciated.

Your consideration for usage of your instrument in this study is greatly appreciated by not only myself, but by those in the continuously growing field of family and child psychology and education. Thank you for your timely response.

Sincerely,

Pamela Vaught, Ed.S., LPC

PLEASE NOTE:

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

These consist of pages:

87-88 Revised Behavior Problem Checklist

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APPENDIX D

Diagnostic Criteria
Attention Deficit Hyperactivity Disorder

Diagnostic Criteria for 314.01 Attention-Deficit
Hyperactivity Disorder

A. A disturbance of at least six months during which at least eight of the following are present:

1. often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
2. has difficulty remaining seated when required to do so
3. is easily distracted by extraneous stimuli
4. has difficulty awaiting turn in games or group situations
5. often blurts out answers to questions before they have been completed
6. has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores
7. has difficulty sustaining attention in tasks or play activities
8. often shifts from one uncompleted activity to another
9. has difficulty playing quietly
10. often talks excessively
11. often interrupts or intrudes on others e.g., butts into other children's games
12. often does not seem to listen to what is being said to him or her
13. often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)
14. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking

B. Onset before the age of seven.

C. Does not meet the criteria for a Pervasive Developmental Disorder.

Criteria for severity of Attention-Deficit Hyperactivity Disorder:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis and only minimal or no impairment in school and social functioning.

Moderate: symptoms or functional impairment intermediate between mild and severe.

Severe: Many symptoms in excess of those required to make the diagnosis and significant and pervasive impairment in functioning at home and school and with peers.

APPENDIX E

Diagnostic Criteria for Conduct Disorder

Diagnostic Criteria for Conduct Disorder

A. A disturbance of conduct lasting at least six months, during which at least three of the following have been present:

1. has stolen without confrontation of a victim on more than one occasion (including forgery)
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning)
3. often lies (other than to avoid physical or sexual abuse)
4. has deliberately engaged in fire-setting
5. is often truant from school (for older person, absent from work)
6. has broken into someone else's house, building, or car
7. has deliberately destroyed others' property (other than by fire-setting)
8. has been physically cruel to animals
9. has forced someone into sexual activity with him or her
10. has used a weapon in more than one fight
11. often initiates physical fights
12. has stolen with confrontation of a victim (e.g., mugging, purse-snatching, extortion, armed robbery)
13. has been physically cruel to people

B. If 18 or older, does not meet criteria for Antisocial Personality Disorder.

Types:

312.20 group type

The essential feature is the predominance of conduct problems occurring mainly as a group activity with peers. Aggressive physical behavior may or may not be present.

312.00 solitary aggressive type

The essential feature is the predominance of aggressive physical behavior, usually toward both adults and peers, initiated by the person (not as a group activity).

312.90 undifferentiated type

This is a subtype for children or adolescents with Conduct Disorder with a mixture of clinical features that cannot be classified as either Solitary Aggressive Type or Group Type.

Criteria for severity of Conduct Disorder:

Mild: Few, if any conduct problems in excess of those required to make the diagnosis, and conduct problems cause only minor harm to others.

Moderate: Number of conduct problems and effect on others intermediate between mild and severe.

Severe: Many conduct problems in excess of those required to make the diagnosis, or conduct problems cause considerable harm to others, e.g., serious physical injury to victims, extensive vandalism or theft, prolonged absence from home.

APPENDIX F

Diagnostic Criteria for Affective Disorder

Diagnostic Criteria for Major Depression

296.2x Major Depression, Single Episode

For fifth digit, use the major depressive episode codes to describe current state

A. A single Major Depressive Episode (see attached description)

B. Has never had a Manic Episode or an unequivocal Hypomanic Episode (see attached)
Specify if seasonal pattern (see attached)

296.3x Major Depression, Recurrent

For fifth digit, use the major depressive episode codes to describe current state

A. Two or more Major Depressive Episodes, each separated by at least two months of return to more or less usual functioning. (If there has been a previous Major Depressive Episode, the current episode of depression need not meet the full criteria for a Major Depressive Episode).

B. Has never had a Manic Episode or an unequivocal Hypomanic Episode
Specify if seasonal pattern

Diagnostic Criteria for Major Depressive Episode

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-congruent delusions or hallucinations, incoherence, or marked loosening of associations).

1. depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others
 2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)
 3. significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)
 4. insomnia or hypersomnia nearly every day
 5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 6. fatigue or loss of energy nearly every day
 7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. 1. It cannot be established that an organic factor initiated and maintained the disturbance
2. The disturbance is not a normal reaction to the death of a loved one
- C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).
- D. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

Major Depressive Episode codes: fifth digit code numbers and criteria for severity of current state

1. Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others.
2. Moderate: Symptoms or functional impairment between mild and severe.
3. Severe, without Psychotic Features: Several symptoms in excess of those required to make the diagnosis, and symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.
4. With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent.
 Mood-congruent psychotic features: Delusions or hallucinations whose content is entirely consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment.
 Mood-incongruent psychotic features: Delusions or hallucinations whose content does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Included here are such symptoms as persecutory delusions (not directly related to depressive themes), thought insertion, thought broadcasting, and delusions of control.
5. In Partial Remission: Intermediate between "In full remission" and "mild", and no previous Dysthymia. (If Major Depressive Episode was superimposed on Dysthymia, the diagnosis of Dysthymia alone is given once the full criteria for a Major Depressive Episode are no longer met).
6. In Full Remission: During the past six months no significant signs or symptoms of the disturbance.
0. Unspecified

Specify Chronic if current episode has lasted two consecutive years without a period of two months or longer during which there were no significant depressive symptoms.

Specify Melancholic Type if there is at least five of the following present:

1. loss of interest or pleasure in all, or almost all, activities
2. lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens)
3. depression regularly worse in the morning
4. early morning awakening (at least two hours before usual time of awakening)
5. psychomotor retardation or agitation (not merely subjective complaints)
6. significant anorexia or weight loss (e.g., more than 5% of body weight in a month)
7. no significant personality disturbance before Major Depressive Episode
8. one or more previous Major Depressive Episodes followed by complete, or nearly complete, recovery
9. previous good response to specific and adequate somatic anti-depressant therapy, e.g., tricyclics, ECT, MAOI, lithium

Specify seasonal pattern if the following criteria are met:

- A. There has been a regular temporal relationship between the onset of an episode of Bipolar Disorder or Recurrent Major Depressive Disorder and a particular 60-day period of the year (e.g., regular appearance of depression between the beginning of October and the end of November).
- B. Full remissions (or a change from depression to mania or hypomania) also occurred within a particular 60-day period of the year (e.g., depression disappears from mid-February to mid-April).
- C. There have been at least three episodes of mood disturbance in three separate years that demonstrated the temporal seasonal relationship defined in A and B; at least two of the years were consecutive.
- D. Seasonal episodes of mood disturbance, as described above, outnumbered any nonseasonal episodes of such disturbance that may have occurred by more than three to one.

Diagnostic Criteria for 300.40 Dysthymia

A. Depressed mood (or can be irritable mood in children and adolescents) for most of the day, more days than not, as indicated by either subjective account or observation by others, for at least two years (one year for children and adolescents).

B. Presence, while depressed, of at least two of the following:

1. poor appetite or overeating
2. insomnia or hypersomnia
3. low energy or fatigue
4. low self-esteem
5. poor concentration or difficulty making decisions
6. feelings of hopelessness

C. During a two year period (one year for children and adolescents) of the disturbance, never, without the symptoms in A for more than two months at a time.

D. No evidence of an unequivocal Major Depressive Episode during the first two years (one year for children and adolescents) of the disturbance.

E. Has never had a Manic Episode or an unequivocal Hypomanic Episode.

F. Not superimposed on a chronic psychotic disorder, such as Schizophrenia or Delusional Disorder.

G. It cannot be established that an organic factor initiated and maintained the disturbance, e.g., prolonged administration of an antihypertensive medication.

Specify primary or secondary type:

Primary type: the mood disturbance is not related to a preexisting, chronic, nonmood, Axis I or Axis II disorder, e.g., Anorexia Nervosa, Somatization Disorder, a Psychoactive Substance Dependence Disorder, and Anxiety Disorder, or rheumatoid arthritis.

Secondary type: the mood disturbance is apparently related to a preexisting, chronic, nonmood Axis I or Axis II disorder.

Specify early onset or late onset:

Early onset: onset of the disturbance before age 21

Late onset: onset of the disturbance at age 21 or later.

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